

Meaningful Use Workgroup

Draft Transcript

April 20, 2012

Presentation

Operator

Ms. Robertson, all lines are bridged.

MacKenzie Robertson – Office of the National Coordinator

Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee, the Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please be sure to identify yourself before speaking. I'll now take roll of the Working Group members, and at the conclusion I'll ask any staff members on the phone to also identify themselves. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Here.

MacKenzie Robertson – Office of the National Coordinator

Michael Barr? David Bates? Christine Bechtel? Neil Calman? Tim Cromwell? Art Davidson? Marty Fattig? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. Yael Harris? David Lansky? Deven McGraw? Greg Pace – Social Security Administration – Deputy CIO?

Greg Pace – Social Security Administration – Deputy CIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Greg. Latanya Sweeney? Robert Tagalicod? Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Amy Ziimmerman? And is there any staff on the line that could please identify themselves?

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Josh.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Mary Jo Deering, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Mary Jo.

Jacob Reider – Office of the National Coordinator

Jacob Reider, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jacob. Okay, Paul, I'll turn it over to you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, thanks, MacKenzie. Now, I guess I'm a little concerned that we don't have enough of our members on here. Is it just Leslie, Greg, Charlene, George, and me?

Eva Powell – National Partnership for Women & Families – Director IT

And this is Eva. I'm a member of the committee. I'm not representing Christine.

Yael Harris - HRSA

And this is Yael. I just joined.

MacKenzie Robertson – Office of the National Coordinator

Oh, great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, wait, so Eva, you must be representing Christine then, right?

Eva Powell – National Partnership for Women & Families – Director IT

I guess so, but I've always been the actual member from our perspective on this committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, I didn't realize that.

Eva Powell – National Partnership for Women & Families – Director IT

Yes, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so then we have Leslie – Greg, are you a liaison or a member?

Greg Pace – Social Security Administration – Deputy CIO

I'm a member.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, Greg, Charlene, George, Eva –

MacKenzie Robertson – Office of the National Coordinator

Leslie, Charlene.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

MacKenzie Robertson – Office of the National Coordinator

I count seven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so hopefully we'll get a few more joined. I think we need to continue and make progress, and we're vetting this in front of the full committee anyway, so hopefully people will join the next time. Is the next call set, and I guess I've lost track, did we get one for Monday, or no?

W

Do we have one on Monday?

W

I don't think so. I think we have to go with the May 1st meeting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. That puts a little bit of pressure on us, but I think it would be nice if we got through either the whole thing, or at least most of it, because as you know May 1st is right before the May 2nd meeting and it doesn't give us a whole lot of time.

What we'd like to do is to go through; we're really just updating, we're reviewing the main committee's feedback that we had from the last presentation we had earlier this month and revising our recommendations as needed. The purpose of this is to have a final recommendation from the Meaningful Use Workgroup combined with some of the input from the other workgroups on relevant objectives and presenting that to the full Policy Committee on May 2nd, which we really have to have approval on before we can quickly turn it around and submit it before the May 7th deadline. That's our goal, so as much as we can get done today would be great. Questions or modifications to that?

Michelle Nelson – Office of the National Coordinator

Paul, this is Michelle. I just wanted to suggest that because there are so many things we have to get through, if something seems like the conversation's going longer than ten minutes I may just let you know that we've spent a lot of time on that topic and we may need to think about figuring out a resolution.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a great idea. And in fact we might even use the small workgroup style so that we can get a little bit better digested input in our last call. Okay, we're going to take it in order except for the very first one. Jacob Reider is very kind enough to join us to talk about one of the recommendations that we had which has to do with clinical decision support. There were a couple of areas where we got feedback from ONC in particular about some of our initial recommendations that may have been covered, particularly in the certification NPRM, and we wanted to make sure we don't address some of the things that are already there. I think I clarified with Steve about the drug-drug interactions, but CDS may already be there, and so I asked Jacob to review that with us so that we can say yes, or here's the difference, this is where we reiterated our five attributes of a CDS intervention. The reason is we're trying to get away from calling something a "rule" when there's lots of ways that you can support the decision making process and we came up with attributes. Our intention was the attributes would go into certification and so Jacob's going to review with us what was in the NPRM for certification and then the discussion here is does that meet our intent, and if so then we can just go with that. Jacob?

(Speaker keeps cutting in and out)

Jacob Reider – Office of the National Coordinator

Okay, well I suspect that folks have the CDS section which we included in the meeting prep today, so if you don't have it double-click on that document in your meeting invite. I was just going to go over some of the certification rules, for those that have it. We separated clinical decision support into several sections, so the first section is ... based decision support interventions. This is most closely aligned to what folks traditionally think of as CDS. One might consider this to be more interactive, whereby there's some kind of algorithm or using the old language rule, a rule that basically leverages information in this patient's record and then presents something or does something.

We were really careful not to be ... about how the system interacts with an end user, and if you look at the first page of the document that I sent along I think the second paragraph is a really important paragraph to read about three times, ... help people try and understand what we're saying. As you know, we can't provide ... interpretation, but we can direct attention to certain segments of the document. So that segment of the document I think has some goals in it, or at least ... it does, in that we say that our goal in clarifying the nomenclature is to focus more on the representation of the guidance, the intervention, and technology should offer the user rather than prescribe the form of the logical representation of clinical guidance or how the intervention interacts with the It's really hard not to say what exactly the system should do. So back to the categories, one is evidence-based decision support interventions, and we say that these interventions should be based on certain data elements, problem lists, med lists, allergy lists, demographics, labs and vital signs. That's the information in the system that this ... should assess and then make a recommendation to the provider.

The second is linked referential decision support, and there's been some conversation in the ... Committee about this one. This is really a decision, we consider this to be decision support by the definition that we ... and the CMS rule essentially references our definitions, so this is another I think it's important that our Reg B or our proposed rule be considered and if you folks disagree with this, there was some concern at the standards committee that this definition is too broad, so we include referential decision support as a textbook research paper, it could even be patient education information, something that would be helpful to the provider in the provision of care, and this is where we recommend the use of the HL7 context aware knowledge retrieval standard, sometimes referred to as Info button. We actually would prefer that this not be called Info button because it implies the use of a button. The standard actually doesn't mention buttons at all. A button would be one kind of way that one would retrieve information, but there may be other ways. So let's stop here, because I've talked a little bit too much. These are two of the key kinds of CDS interventions that we talked about in our regulation and

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, Jacob. Comparing this list to our five attributes, I think there are a couple of differences that may, I just want to ask you whether you think it's covered. One is this 3B: Enable interventions to be triggered based on data amount specified when a summary of care record is incorporated. Would you mind explaining that a little bit, Jacob?

Jacob Reider – Office of the National Coordinator

Sure. This one basically says that if a healthcare provider is sharing information with other providers in a community the system should be capable of incorporating that information too. So let's say the patient was put on a medication that interacts with a medication I prescribed last Tuesday or that I'm about to prescribe, if that information is available in the community and if that information has been incorporated into my ... the clinical decision support should be capable of doing this. Now this doesn't have meaningful use implications, or perhaps it does, but for our purpose we just want to make sure that we were proposing that the EHR be capable of making this available. A use case would be in that scenario I just described if we didn't recommend that the EHR be capable ... we're concerned that the information that might come in from the community wouldn't be incorporated into the record in a form that CDS would be able to interact with, so perhaps a new lab data value comes in, or as I described earlier, a medication, the patient's put on a med and the med isn't incorporated into the system in a form that CDS can leverage it, so it couldn't be incorporated into drug-drug, drug allergy interaction checking, because it's in the same kind of form. So really our intent here was to prepare the systems ... information in a way that it could be leveraged by CDS and that CDS could leverage that data. Does that make sense?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, it does. Can I ask a clarifying question then? It makes sense that that information would be incorporated in decision support. In a sense it would if it is, one, structured; and two, I'm going to use the term "accepted" into the receiving organization's EHR. So if it's a med and it's recognized as a med, it's understood as a med, and which med in the receiving system, then you're saying it should be incorporated. I guess there could be questions about well, is it a med, it's free text, and the system does work in a standard form that is not known to the receiving system, maybe this is a bit too much in detail, but you can see where there will be questions on how you make sure that that does or doesn't happen.

Jacob Reider – Office of the National Coordinator

Absolutely. Now if it's incorporated in the summary of care record presumably one would use the standards that were specified elsewhere in the standard and certification requirement. Yes, to your point, if it's free text, if it's a PDF it could be in a summary of care record but it would be in a section, so maybe there's a free text progress note that mentions a med that was included, so technically it would be in the record, but it's not in the record in this segment that would be expected and therefore it wouldn't have been incorporated into the system and therefore it couldn't be used

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, other comments?

M

Paul, number one, enhance the source citation criterion as a hyperlink to peer reviewed literature, it seems like that's covered. Configurable, I think I saw that as covered, right? Going to three, presenting a relevant point to the clinical workflow, it's not explicitly covered here. I don't know if that would seem to be an example of specifying how the things should be used. Number four –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. The standard allows for a test within the EMR to be passed as part of the context, so, for instance, I would know if I'm in CPOE ordering a med, and so the med information would be boosted above the condition information.

M

That's part of the Info button –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Yes, exactly.

M

I agree with that. But in general across the entire clinical decision, the EHR certification criteria for patient support in general, it doesn't explicitly say presented a relevant point in the workflow. I don't know if that's assumed. Presented to –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I don't think you can pre-determine the relevance. I think that that's something that –

M

It's not something you can certify.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Right, if the contextual ability is there then at least you know that any time you evoke the request you have contextual reference. And so the use of the standard allows for us not to have to pre-determine where relevant workflow is.

M

Okay, and then presented to users who can act on them, that's not this part of the certification criteria, I don't think. Can be integrated into the EHR, I think that's versus standalone. I think that's implicit in here. So Paul, the question is, do you want to repeat your five again, or do you want to say that the certification criteria adequately includes the proposed clinical decision support attributes? What's our outcome here? We either just say our five things yet again, or we say that it's covered. Which one are we saying?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I think it's covered as long as the Info buttons standard stays in.

M

Well, Info buttons just address relevance for the referential documents, not for, for example, alerts, which we don't want to say alerts, but nowhere does it say that the alert should be presented, not at the beginning of the day you get all the alerts for your whole panel, but you get them while you're ordering stuff on that patient. So we're not saying that explicitly now. I understand the standard supports it, but it's not being said that that has to be done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Do you know what, I'm going to take Michelle's prerogative, I think. This sounds like we're definitely down into details, and I wonder if this is good for a small group, like George and Leslie, and I'm happy to participate, in looking at some of these details. I think some of the questions are, is it even possible to specify it at the level of detail and just make sure we kept the intent without being over-prescriptive. But it sounds like we're in details that could be worked out and then we can come back and present a recommendation back to the workgroup. Does that make sense?

M

Okay, you have to be on the workgroup because these were your suggestions in the first place, so I think it would be important.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, I'm happy to. Okay, how does that feel to the rest of the members?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

You can count me in. This is Leslie.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and Paul, I think just one comment is the more you can align between what's in the NPRM, the Meaningful Use one, and what's in certification with ..., it will just make life a lot easier in implementation land.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think the reason we are spending time on this is we all said that really CPOE and CDS, it's at the ordering stage when we can get as much relevant information to bring to bear on that order where EHRs have a huge impact. So we want to make sure that we get this right. It's got to be one, flexible, and to be able to do it at the right time, right person, etc.; and two, not be over-prescriptive; and three, not be big, and that's what Charlene was just saying, so I think it's worth a small group of us trying to get together and nail down some of these details and coming back to the full workgroup before we go to the full committee.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good. Thank you, Jacob. And I think it would be worthwhile, obviously, to have you participate in that small group as well, just so we get all the intents and discussions in front of us.

Jacob Reider – Office of the National Coordinator

I'd be happy to do so, and thanks for having me today.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. Okay, the next topic then is CPOE, and we basically said we agree of course and point to the other two order types, lab and radiology. We went ahead and agreed with the different kind of numerators instead of the 25, and now looking at the green, here are what some of the comments were back from the full committee. I think the number one comment, it was a question but I think we answered it, in other words, if you order a panel then it's the same as ordering all six, let's say, orders, and that appears both in the numerator and denominator. I think that was the intent from the NPRM and that was our intent as well.

One of the requests, scribes was a big issue, it's part of orders and then it was also spread to, let's say, does that include progress notes in terms of our opinion as far as it being – we came back and said we didn't think scribes were the appropriate party to be entering an order, because we didn't think that they would have the authority and the license to be able to act on the CDS that might appear, and so our recommendation back was that it's still ... with the licensed professional language from Stage 1. One of the requests is can you make sure that you define what you mean we mean by scribes and does it also apply to progress notes, so does our request that these be licensed professionals apply to the use of scribes in progress notes. Comments? Maybe we ought to take this one at a time. Back to orders, I'm not going to regurgitate all the rationale we used for the licensed professional, do we have any change in opinion and sentiment about that? I think we were unanimous before, so it seems like we're still unanimous.

Okay, so we probably can put some additional language about scribes and our understanding of a scribe is someone who is acting as an intermediary to do the clerical task of entering, and when the word "scribe" is used, is that person implicitly is not licensed, so is not responsible or accountable for that order. Now let's –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. They could be, correct, I mean, it could be a nurse, not licensed as a physician obviously, but you could have someone asking on behalf of a physician that has a scope of practice that is clinical.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, Leslie, that's what we meant by licensed, in the sense of –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Okay, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's where we're headed. For progress notes, I don't think our intent was to interfere with however people are getting the progress notes into the system. Is that true?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Now we also recognize that progress notes isn't a ... objective at this point anyway, but we can clarify that. I think they wanted a whole lot of detail and we're happy to provide that.

W

Paul, I think our intent was just we recognize that the more we can automate the processes such that a robust record is there, let's take a source step of starting to get them in, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

W

So we didn't get too much more complex than that except it should not be hand written, scanned.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Okay, now the next bullet talks about, somebody asked the question, shouldn't we just make sure that the person who eventually signs off on the order be a licensed professional or the authorizing provider. Certainly our intent was that we're helping to shape the order as it's being constructed, so at the time you are deciding on an order, you would like to be influenced by all the relevant data. Now, that's not just, it could be a lab test like a renal function at the time you're writing a med order, or even a lab order, or the availability of test results that are recent to one that you're about to write essentially a duplicate order. So there are lots of reasons why you'd want to shape the order at the time you're even thinking about it. That was where we came from in terms of trying to get it at the time of writing. How do you feel about just making sure that a licensed professional signs off at some point along the path? Is that clear, people were asking the question of okay, as long as somewhere along the line that a licensed professional is involved, is that good enough from a CPOE point of view?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, now you're saying that, for example, if a scribe enters an order and later on the physician signs off on it, is that good enough? Are you saying yes?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Just because, the only reason I say it, is that's what we see in practice today, and I know Neil's not on, but he would say he's still overall accountable, right? The end game is so that the decision support can be at their fingertips, and it doesn't get at that goal. The reality of the practice is that's actually what happens in some practices, that's where I'm struggling. This is Charlene.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. There was this discussion in the Standards Committee about this too, because information comes in asynchronously, right, I might have new information on the record but it doesn't appear to me in an alert until the next time I actually come in to take action on that patient, is one scenario. Or, also I might have information that comes in, in the background, that could fire an alert in the future, that a person may not even be in that ordering screen that it comes into as a message. So this idea of having to accommodate asynchronous use as well as accommodate multiple party was discussed, and actually requested that the Policy Committee spend some time discussing, okay, what does that mean. And Neil's point in the earlier meeting was I'm accountable no matter what, no matter when that information is taken it's on the physician of record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me separate, I think that's a separate issue. It's an important issue, but it's a separate one and let me describe how. One is at the time that you write the order just writing the order has relevant information. As a separate thing is now if you're not the authorizing provider you've inadvertently created a time gap and you get into the situation that Leslie just described, that is, between the time your order is entered in the EHR and the time it is signed off on, new things can arise, so that's actually another reason why you'd want to move it all to the first time, during the first thing right at the time.

Let's separate that for a moment. If we agree that it should be an accountable party enters the order, then we actually get rid of that second problem. Do you follow me?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Yes, I do, Paul, and I'd defer to your judgment on this. I think the discussion was what is real practice and how do we account for that asynchronous and other people in that process?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we've all been saying CPOE and CDS are really one of the most important benefits of using an EHR. One of the things is giving information at your fingertips, but the other is how do you make better, more optimal decisions using relevant information. And understand the diversity of practice is now is this one of the key things, and I think that's the question that's being called, that you'd actually want to change some practices.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's actually up for discussion.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, this is George. Given the proposed new format where we're not trying to write what the policy could be, we're giving the recommendations that will then be discussed on May 2nd by the Policy Committee, I think we're allowed to put forward our opinion and not try to guess their reaction to it to the same degree that we used to. And remember that we may get comments now by the Information Exchange and Security Workgroup that could also comment on scribes or not, the way it's going to be set up. Therefore, I think it's important for us to express what we think is best, and not so much guess where it will end up.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I agree.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

And the NPRM, I think, says licensed professional, doesn't it? We were asked to comment and we said yes, it should be a licensed professional. Do you guys remember, does it actually say licensed professional as –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

They changed it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

What's that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I thought they had changed it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

All right, I'll look while we're doing –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Actually –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I would stick with licensed professional in our recommendation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I have it. It's in the matrix. So use CPOE for med labs and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines. So they kept what we, but they were asking about, because I'm sure they heard about, the use of other non-licensed scribes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Since the rule itself suggested it and this is our feeling of where it needs to be, I would just leave it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, as our recommendation we continue with the licensed professional and we would say the licensed professional must enter the order, not just sign off on it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

As you know, usually in these discussions I'm pushing hard for making it feasible, but in this one it's like I don't know why we're doing this if we're not doing this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, that's the point I'm trying to make.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It just becomes like a big politically correct documentation system. This is the intervention right here, period; the whole \$30 billion is for this intervention. If we're going to back off on this one then I don't understand how we got here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's your opinion. Do we have consensus around that sentiment?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. I will support that. Again, we don't have our other caregivers on the call with us.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm pretty sure Neil would support that as well.

W

I agree that this is the emphasis and this is definitely what we want out of it. I'd measure that a little bit with the actual practice. However, meaningful use is a stretch goal and I'm really thankful that we just were just reminded of that.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Greg Pace – Social Security Administration – Deputy CIO

This is Greg. I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you. Okay, so we'll go forward with that. The question about who cares about the liability, yes, no matter where this person enters their name, wherever the licensed professional enters their name they're part of the liability chain.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let's move on to drug-drug interaction. We actually, interestingly enough, had public comment from one of these vendors who supported our recommendation, and just to clarify, yes, we understand that the certification NPRM says that the vendor, the knowledge base needs to be able to triage these things, cure these things by, for example, severity, another way it's done is by timing acutely versus delayed reaction, but our intent was really to give customers, end user organizations, the ability to use things that have a higher positive predictive value, a lower false positive, and higher accuracy in terms of an actionable and meaningful alert. And this is on the way to other means of getting the high yield alerts, because this truly has been one where it's not only been a low yield decision support, meaning high false positive, but that kind of thing gives you alert fatigue and can impact other decision support. So that's why it's so important to us. It is true that more research needs to be done. We were aware of and we had a presentation to this group from Rand, who is working on some of the never kind of events, but I think they're also looking at other ways of categorizing alerts by their yield, by the positive predictive value, so we are calling for that as well. Any change in that sentiment?

M

No, I think what we have in ... is good and the rest is comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. Okay, let's go on to the next one, which is the ERX, Stage 1 was 40% and we recommended 50%, and the NPRM went up to 65%. Input from the IE Workgroup said that they were concerned, probably as we were, that 65% may be encroaching on things where there are legitimate reasons why we can't meet a higher threshold. Even though you have the mechanisms in place, you've got to have the mechanism in place to reach 50% or even 40%, but there are times, whether it's ... or the patient wants to take the physical paper that that may impact your total percent. Now, Terry mentioned wanting to keep this consistent with the ERX incentives. Now, does someone in ONC know where there might be any differences, if any, or CMS? Is that maybe something –

Michelle Nelson – Office of the National Coordinator

Paul, we can follow up and get more information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thanks, Michelle.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Paul, this is Leslie. In the Standards Committee we did discuss making sure that the ePrescribing standard reflected for inside organizations the ability to continue to use their HL7 interfaces and then go to the more broadly public ERX prescribing mechanism, and that seemed to allay fears too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good. And Leslie, am I remembering correctly that there was going to be some data from Surescripts that you're going to get to help us understand whether 65% is appropriate?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Was that on my to-do?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No. Just as part of standards did you hear that?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

The issue was that doing the Surescripts kind of thing was very popular, just not inside a hospital or inside an institution.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Michelle, I wonder if you could also follow up perhaps on that, because I think what they're going to do is look at data, and here we're thinking about rural areas, whether the penetration is high enough to reach 65%.

Michelle Nelson – Office of the National Coordinator

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. Okay, next page, I'm on page six –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, I just put down that we recommend 50% pending finding these other things out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The first thing about demographics, the question was raised are we using the demographics for anything, and I think the answer was, yes, and we can refer back to it when we get to patient list, one of the things we did do is say, we upped the number of variables used from one to two or more, and we can put more in our preamble about thinking that one of the areas you would want to create lists is to understand the severities of care.

The next one is the med allergy, and what really ... is the up to date problem med and med allergy, and we had put in our recommendations that we thought it was appropriate to keep it up in its own categories because we were thinking about moving to functions that would help providers keep these lists up to date, accurate, etc. And that's a placeholder for us. We need to make sure we cover that in developing Stage 3 recommendations. Any change in that?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Paul, there was a question about if we wanted to keep it separate for medications then does that also give opportunity to add non-medication allergies like dietary, like patient intolerances, with this separation were we looking then at expanding allergies?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we did talk about it, and this group in the past has felt that we needed to concentrate on med allergies, unless there's any difference of thought now.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The big change, we've had that feedback before and we've seen that in terms of the allergies, but I think the big change we're going to see this time with keeping these here is in the Standards Committee, again, these elements are now adhering to a more common standard, so this will still really raise the bar for people, I think, because in Stage 1 you could code it and now, for instance, problems have to be coded in SNOMED, we could have coded them in ICD-10 last time, so the bar is still raising with these requirements.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a good point, we want to keep people focused on this is changing workflow.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, this will change.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And in a direction we believe is on the road to –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... part of the rationale for keeping them as separate objectives, or at least problems.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. I think in answer to your question, Leslie, it's fair to raise, we did cover it, we're still trying to keep our eye on the prize, and with the parsimony principle in mind.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. Okay, let's skip over, we have a number for completeness of the decisions we already made. We can skip now to page 10, and on that it's the hospital labs. We had proposed that we do have the hospital labs transmit results in structured form for over 40% of the orders they receive. The question that is raised is whether that puts an unfair demand on hospital labs compared to free standing labs, hospital labs accounting for something like about half the market. We felt it was important, and it looks like the IE Workgroup also felt it was important for hospitals to return results in structured form using LOINC where possible. Any change in that sentiment? This was assigned out, delegated out to the IE Workgroup, this is their recommendation, and is there any reason we wouldn't support that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

When we discussed it we had a mixed feeling. Some people felt like this was important to do and other people felt that it was out of scope for meaningful use, put an unfair advantage to non-hospital laboratories, those kinds of –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

We previously had a mixed – I don't think we came to a decision really.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I think the reality is if the hospital laboratory is providing results out to other providers and they have to also do LOINC infrastructure format anywhere, do it once with many objectives.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think you're in support of the IE Workgroup recommendations then, correct?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I am, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. We have some customers who they've actually tried to do it with the practices and there's been some financial constraints in the ability to be able to do that, so I would recommend, if we're going to put it in, I suggest it as a menu item if we're going to endorse it. I just think there's going to be some barriers to doing it out there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

What Charlene is saying is the barriers to hospital sending labs in structured form.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, because we've had customers that actually have tried to do this before this was ever a requirement, and the practices wouldn't take the data.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Oh, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So they didn't have anyone to send them to. I think we could get –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

That's a great point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good point.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

We could get started with this, because we don't have many menu items anyway, ..., right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

For hospitals they have to pick three out of five, or did I get that reversed? One is two out of four, and one is three out of five. Does anybody have that with them?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

..., which I agree, the advanced directive a requirement ..., we took one of them away, which I support.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So we'll substitute this.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a fair compromise. What do other people think? So the latest suggestion on the floor is keep this recommendation but make it menu, and what that does is of course that's one of our strongest signals, so the menu's been a good way of making a signal, one that you can count on. I think vendors like to have more than just preamble about what you're thinking about doing. Menu, I think they can rely on something being a very strong signal that can actually apply to development resources too.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. Is it consistent with the CLIA direction on providing results directly to patients? I just want to make sure that we're synchronized there.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is to –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Otherwise I agree with Charlene.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's a separate recommendation.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. And, Paul, the other constraint, the reason we pushed so hard earlier was because the certification didn't allow you to do, you had to do that complete certification or possession certification stuff and that was addressed with the improvements in the certification process. So you could just do this one aspect and be okay, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

You just have to do this complete possession thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't get the possession, could you explain it?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The last time you had to possess all those elements to be able to attest, and this time through, for instance, if they choose it as a menu they don't have to possess that element of certified software.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. I think that does help.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It helps. That's some of the pushback we were getting last time, that the certification process made this really complex.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the burden of having a menu, so the advantage of having a menu is the flexibility to the provider, it's also a strong signal to vendors, and whereas it was a burden because then all of a sudden everybody had to have that, the change in the certification, the post change certification rule really removes that burden.

Josh Seidman – Office of the National Coordinator

Paul, this is Josh. One of the things the IE Workgroup talked about was they had suggested, and why they came to a unanimous approval on this one was in part because of the increasing threshold on EPs on reporting structured lab data. So I think their feeling was that it needed to be a core requirement for hospitals in order to help EPs to meet the structured lab data which was moving from menu to core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you, Josh. That's the counterpoint to Charlene's ..., so a very good point. Does that make us think of this more as core versus menu?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I think any time there's parsimony it should be core, any time we're looking at something that's different it's difficult.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the good thing is, unlike labs, who are not covered in the incentive program, hospitals do have an incentive to participate and yet this may be an additional requirement, I don't want to say a burden because it's really part of the service they're providing. They are asking at the lab that you get revenues from that and this is a way to consume it in a very meaningful way for the provider and patient. That's an argument that says let's just move on with it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George. I guess I'm just supportive of Josh's position. The other thing we could –

Josh Seidman – Office of the National Coordinator

It wasn't my position. I was just reflecting the IE Workgroup.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

A statement, yes, thank you. We can also remain silent. I don't think we should remain silent. We should probably say something.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's call this question so we can move on. Who wants to make the motion that we'll vote on? I'll use the last one that I heard then, that we would support the, in fact, we delegate it to IE so that's a good anchoring position, so that we support the IE recommendation that we restore the HITPC recommended requirement for hospitals and structured labs using LOINC where available.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I suggest an amendment. Forget the IE Workgroup, just say what we want. We suggest that we restore the –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

If that's what we want. That's what we should vote on, do we want to do it.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. I'll vote yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Others?

Greg Pace – Social Security Administration – Deputy CIO

This is Greg. I'll vote yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. I'll vote yes, but it's still going to be a challenging one. Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But it's still a yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... I know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's nothing if not challenging.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I already voted yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Eva?

Eva Powell – National Partnership for Women & Families – Director IT

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Anybody else? Yael, are you a voting member? You might be a liaison. Okay, and I'll vote yes. Okay, let's move on. The next one is on page 12, and this is in the engage patients and family and we're talking about the view, download, and – so the main concern here I think we're fine with the online access in a time frame and the main concern was the second part of the measure, which required 10% of those seen to have actually viewed, downloaded, and transmitted. When we discussed this, the other concern really is whether the provider is held accountable for the patient actions, but also is the penetrance of this kind of technology, either broadband and use of the Internet in this way and in healthcare sufficient enough to get to a 10% of those seen threshold.

Eva Powell – National Partnership for Women & Families – Director IT

Paul, this is Eva. I've been doing a lot of thinking on this, because I recognize that it's a difficult step and at the same time I think part of what we've learned from Stage 1 is that the notion of just making something available without ... some sort of flag to the patient that things are available, particularly in this new environment that is really unprecedented in most people's experience, just really isn't an effective way of actually engaging patients. But at the same time I certainly understand providers' concern about being held accountable for something that happens totally outside the realm of their control. And so just in thinking about what is it really that we're trying to do here, and I think in these early stages of people getting access to their healthcare, at least in my mind the critical thing is actually having that patient see their information for the first time, because to me that's where the power is. And that's to me the watershed moment for people who are going to be inclined to make use of that information and people who just aren't regardless of what their provider tries to do or helps them with.

So I know there was a conversation last time about using the secure messaging to help get at this, and I think that's still very strong support for this measure and I actually would be inclined to prefer that measure be in the locus of control of the provider because to me it's a more natural thing for the provider to initiate that communication, and what that does for the current objectives that we're discussing now is it provides an inherent tool for the provider to expose the patient to this information through a form of communication that most patients prefer.

The other thing I've been thinking about this is, and I don't recall a conversation on this, but I could have missed that, to me it's also more effective, again, getting at this watershed moment of the patient actually viewing for the first time their own health information. To me the better setting to do that in is not necessarily at home alone, but in the context of the So is there a way to keep this measure at 10% of patients actually logging on to view the information, but doing that in a way that if the provider decides that part of their strategy for meeting that is actually giving them access to their own log-on information, that they can then do at home if they choose to do so in the context of the clinical visit to show them the information that then achieves the watershed moment that we're after of actually having access and seeing the power of the information. But it gives the provider an element of control too, because again it's something they can do.

And to me the other important part of that is that even though that will require some workflow change, I think that's exactly what we're after, because what we're after is creating a workflow that doesn't just check boxes of clinical care, but that actually supports the patient in their role once they leave the clinical setting, and to me this is a critical piece of that workflow change. And it doesn't have to be the physician that actually walks the patient through, although certainly it could, it could be a nurse, it could be a social worker, it could be a therapist, whoever, but is that a workable solution to this, retaining the 10% log on

and view, but allowing for viewing in the context of the visit. And frankly, I'm not sure how you would necessarily tell whether that patient logged on from home or from the clinical setting, and then putting the secure messaging locus back to the provider, but with the stipulation that that has to be a personal message, it can't be an e-mail blast.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Eva, I can probably respond to your question and suggestion. We have a lot of experience; we have three-quarters of our patients online with it. I think you're right that just the discovery that you can get access to the information is probably the most potent thing you can do to engage people. And it turns out that our workflow does include having essentially the MA, have them log in for the very first time in the exam room and we make it easy for them. So that's one of the ways that we figured out on how to engage people and get people to sign up. What I might want to suggest, and this is very consistent with the IE Workgroup's suggestion, is instead of 10% of those seen during the period, what we're trying to do is get people to "log on." Logging on really, the process, it captures the authentication, that the hardest thing is really authentication, make sure you know who's logging on and that they understand the rights and responsibilities of this access. So log on is a simple word, but it's a very complex and important engagement.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the fact that if we wrote this and that's how it was originally written, that 10% would have logged on, not just signed off and say, I'm interested and that kind of thing, but actually logged on, that's a meaningful goal and also a reasonable goal in terms of 10%. I think making it 10% of those seen changes that into less reasonable and it sort of becomes a bit more burdensome than what we really wanted, which is that initial engagement.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The way I would address this –

W

I don't get your distinction, 10% of those seen versus 10% of what?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So 10% of your active patients have logged off. So over time we might change something with that percentage threshold or there may be other outcomes, more outcomes related things that we can measure. But I think getting people on board, on to the escalator, is making sure they think about the workflow, etc., but getting people engaged to get through your watershed event I think is important and could be achieved by having people log in. Just to restate that, the criteria would be 10% of your active patients, so those seen within the past two years have logged on, and that –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Paul, this is Leslie. If the delivery of the information to patients is through Direct, then obviously being provided by a ... portal, so I just want to make sure we're not too persuasive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, again, it goes back to ... log on, that means you have engaged, you have authenticated yourself, you've agreed to the terms, and you created your password, in a sense, your ID and password. All those would be true in all three of those, access, view and download, access and download.

Greg Pace – Social Security Administration – Deputy CIO

Paul, this is Greg. I just want to make sure that by patient we have not lost sight of it could be the patient or their authorized representative.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, correct, good point. Let's make sure that we capture that somehow.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

All right, so you're saying that they don't actually have to view any data, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

By logging on they can avoid viewing. It's the –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... . They don't have to have done it in this period –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. That's the main difference.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Like you said, Paul, the practice could own it, right, and establish the process with it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And so they would have some control?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Right, that's correct too.

W

So what did George just say, that they wouldn't have to do it within the context of the visit, is that what you said, George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Well, the visit would be great, but we're not stipulating that it –

W

Oh, right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

The more important thing is that it doesn't have to be that reporting period. If they logged on a year ago they still count towards your numerator.

M

Right.

W

Right, if it's the two year.

M

In other words, if a patient tries it and decides they don't like this, we don't penalize the doctor.

W

Oh, yes, yes, yes, absolutely. And I guess part of what I would want to accomplish with this is to provide as many avenues for meeting as possible, one, because not every patient is the same, and if you're a practice in a fairly wealthy neighborhood with very savvy people one thing might be effective, whereas, you may be providing care to underserved populations who have ... and can access it that way. My hope would be to not stipulate too much, but to ensure that you can't get credit for this unless the patient has actually seen their health information, and the context in which they do that is irrelevant. Well, not irrelevant, but that we don't necessarily care about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Other comments?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, once you say logged on, I'm a little worried that transmit may not count as logged on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That was the point Greg raised, so really –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, ... about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

... it's the process of authentication and having signed your user agreement and establishing yourself. So it's hard to come up with the words, but any way in which you give permission and you authorize the access download or transmission would count.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, that's what I meant, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great.

W

I think you said that on that one, registered or something, but I like that.

W

And we keep the 10%?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, 10% then of active patients is a very different –

W

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's controllable. It achieves what Eva described, and through best practice it would go even closer, and it's a start.

W

Yes. And on the point about transmit, obviously people need to get credit for transmit, but I'm not sure what your point is, George. Are you saying that there's a way to transmit without logging on?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

In other words, you go to a doctor's office and you say, okay, transmit my data to Health Vault for me, and you don't go home and do anything. It's already done.

W

I see. I see.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So that would probably count toward your numerator.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But that's part of the registration process, right?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Registration would say your communication intentions.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And the most common way of that happening is you basically log into the receiving system for which you've been authenticated, given permission, and authorized. So I think we've accomplished those things.

W

Right, so I guess, just for clarification let me make sure I understand what you're saying. If the patient is in the context of a visit and says to the provider just verbally, please send my stuff to my Health Vault account, then I would assume there needed to be some written authorization to do that. But that written authorization does not count. It only counts until when the provider sends the data and the patient has logged on to, as you say, Paul, the receiving source.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Typically the provider has no control over that transmission. It's really under the control of the patient. The way that it happens is you logged on to Health Vault and you say, I've got this account in system A and I'm going to log in. So it's really out of the hands, nor would the provider even be able to make it happen, really, because we can't I think this is actually a very nice compromise, it's not even a compromise, it really accomplishes a lot of the objectives.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, personally I think it's a better way to accomplish it. It's more natural and it provides an opportunity for the patient to get the information when there can be some explanation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we have agreement with that?

W

It sounds great to me.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It sounds okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It's a huge stride forward –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It is.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... a lot of the issues that were

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It is. I really do think it's a huge stride for, what you would call the watershed, and yet it's not onerous to try to figure out how you

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let's move on to page 13, it's a similar thing, and this is a secure message. We proposed 25 to try to overcome a number of the burden. The NPRM said 10%, and what we agreed on last time was it's not the activity it's just the threshold and so we came up with what we thought was a more reasonable threshold of 5%. You could think of that as 10% of 50%. That's where we left off. There was a discussion about timeliness. I can give you some data we have. Timeliness is not an easy thing. You might think it's easy, but a lot of ... actually are just letting people know something, it could be even a thanks for doing that, or I'm feeling better, there are a lot of things that come in that actually don't require a response. So although we have a timely measure as well, it's very hard to do, it's approximate, and then you have all kinds of – any time you measure something that's not truly measuring what you're intending you cause complications that may actually overburden and have such unintended consequences you get in a bind. That sort of caution about trying to, at this early stage, this is our first foray into this, of trying to get a complicated measure versus just saying hey, are people who want to take advantage of this method doing so. And that's why I think some thresholds that are very low thresholds, so there's lots of extenuating circumstances, is a good approach. So that's ... providing data into this discussion. First, does everybody feel comfortable with the 5%?

Eva Powell – National Partnership for Women & Families – Director IT

Well, I guess this is the point to maybe talk about what was discussed at the meeting, and I don't want to revisit something that's already been decided, but my understanding is it's the 5% of patients who actually send messages, is that correct? So the locus is still on the patient.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It is, yes, that is correct. That's part of the thinking that was going to, there are so many conditions for this to happen that in our very first foray into this we don't want to scare off people and we just want to start that engagement process. Ten percent may be too high for across the country, but it's the across the country part.

Eva Powell – National Partnership for Women & Families – Director IT

Yes, I guess what I am thinking is that to me it just makes more sense to move the locus to the physician, so instead of patients, what is it, 10% of patients send a secure message, to have, and I don't know what the threshold would be, but a slightly higher threshold, and say whatever percent of providers send patient specific messages to their patients. And I don't want to make a big deal out of this if it's already been decided, but it seems to me like we might achieve more by doing that. First of all, it would probably make the providers feel better that, again, this is under their control, and it then means that this can, to me it's a more natural way to set this up for being a complement to the view, download, and transmit measure.

I don't know, just thinking about this logically, as opposed to the portal the e-mail is a bidirectional thing and while the portal hopefully will be one day, it's not necessarily a means of communication. But the secure messaging is, and if you have a provider who's messaging a patient who really wants to have e-mail communication with them, they're going to get a response. The patient's going to send a response. If you've got a provider who is e-mailing somebody who doesn't necessarily use that as a way for their communication then they might not. But I don't know. I'm sorry if I'm complicating it unnecessarily, but I'm just trying to think about how we can get the most benefit from this without over burdening people or creating unintended consequences. And I understand the concern about having too high a percent if the locus is on the patient, but if we move that to having the locus on the provider it would seem to me like we might be able to do more. But what are other people's thoughts on that?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. It looks like the IE Workgroup recommendation is to change the ... to include provider generated message to patients with some type of verification that the patients have received the message. So it does still keep the burden on the physician or the clinician to send something. Can we keep the high percentage, or is that off the table at this point in time? I'm confused by the comment, it says 10% for physician generated, and 5% for patient initiated messages.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm not sure where you're reading. It says –

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I'm reading on the actual April 12th ... PowerPoint that was attached.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right now the 10% and the 5% refer to patient generated.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Okay, so I'm reading this incorrectly then.

W

The 10% is what's in the NPRM and the 5% is what the group discussed in person.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Paul, can we do something like around that active patients and ... this e-mail communication with some percentage of those active patients to parallel that other one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's an interesting thought. It does, and I think that's fine if we wanted to do that as well. Just to respond a little bit to Eva, it's interesting, the objective here is to give patients more convenient access to their health teams, and so really you want the measure that we design to measure that part. And recognizing that that is a patient initiated action, that's why it's so important, I think, that we have a very low threshold, so that we don't get into all of the complications. Now, if we move it on to the provider side, then one it's not measuring our intent, which is convenient access from patients to providers; and two, there's obviously ways to ... the system in the sense of not doing the true intent. That's I think the original reason

why we had talked about; one, it's patient convenient access to providers, and then recognizing all of the things that may be extenuating or reasons why a patient wouldn't have the need to, and one of the areas of course is pediatrics, is why we put a very low threshold. That's just to give you a background for our original thinking.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, this is George. Remember that we already have providers sending reminders 10% and we –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... patient educational materials so what message are they going to send now that's not either a reminder educational, do you have the same message count for all three. As you said, the purpose of this was ... back, and if we think that's a bad idea then get rid of the objective, don't take another provider objective to send more information.

W

Yes, and I think our intent, I guess what I was thinking is that, again, going back to we were talking about radically different ways of providing healthcare and patients may not, given that it was more natural to me for the provider to initiate the possibility by, say they had a visit and they had lab results and come in after the visit, then the provider could e-mail the patient and say it was great to see you yesterday, your lab results are in, and you can now go to your portal and see the results. Please call me or e-mail me if you have questions. And that then is the impetus and again just by the way people act is if you're sending that to a patient who wants to have this kind of communication they're going to respond. But I think a key part of that was the timeliness element and so given Paul's information about that it does, I think, make more sense to keep it the way it is. Yes, sorry, I didn't mean to interject any discrepancy. I was just thinking why would a patient think to e-mail their doctor if they've never been able to before.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let's see if we're getting any consensus around our previous recommendation, which was to lower the threshold from 10% to 5%, and keeping it as patient generated messaging.

W

Yes, I think that's good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It's hard to ..., like you said you can't send out reminders for appointments and all that kind of stuff. What's relevant if you're ... from the provider?

W

Yes.

W

Forward to where this is a normal process and you might have a tool for the patient to list their daily blood pressure, you might have a shared decision making tool, you might have something that's a home telemetry device ..., so this is really laying the groundwork for the future, that the patient is generating and initiating information back to the physician.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, I like that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is ground breaking, so let's not break the ground also.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

You might have experience here. The only other pushback I'm hearing is that it's around there's just some providers when you're in for a consultation there's just no need to e-mail, so there's a set of those where there's going to be some exclusions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a good point.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I don't know how we deal with that, they'll just be exclusions, but there will be some exclusions in this space. Maybe it's like if there's only one visit or something they're excluding, something like that, because you've defined them, so these will be active patients again.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, but you bring up ... and we're going to have that in another objective.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what you were just about to say, I wonder if we can put some language about continuing care. Now that will have to be defined, but clearly obviously primary care is continuing, specialty can be continuing, a one-time appendectomy or cholecystectomy is not continuing, but if we could come up with some definition of what continuing means then maybe that's the way – that's the intent anyway. Because you're exactly right, we don't want to have either party, doctor or patient, having to right a message when there's no need. Then actually –

W

The hospital might want to retain an ongoing relation even after an episodic –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure.

W

... event.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So that's the importance of how we define continuing, if that's the word to use. And then we have to think about pediatrics.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And I think this is another one where it will be really important to say "or authorized representative," because I honestly see pediatrics being a place where this is taken advantage of most, because new parents are wanting to communicate and they're also of a younger set and therefore probably inclined to use this feature. Then you've got also the caregivers for chronically ill folks, in my mind the caregiver set, whether you're a parent or the caregiver for an older person, they're the ones that are going to find the most value here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so two concepts that we've introduced and we want to come up with words around them; one is the proxy, the representative, and it works in both age spectrums; and two is this notion of continuing care so

that we don't create a need for unneeded messaging. So those are things we do have to do and we probably can come back at our next call and approve the wording. Good, I think we made progress.

Okay, our next area is page 15, slide 15, having to do with the HIE test. Now, you recall from the NPRM that they suggested removing it because really this created, the goal was simple, there are two things: to get the functionality and certification for the EHR and to get some thinking about it to happen, so that's ... a test and you can either pass or fail. The complications from either understanding it on the provider side, or implementing it and executing it on the whole attestation is really enormous and I think that's ... for the suggestion that they would remove it. The IE Workgroup agreed with that and said, and the NPRM offered four options. The IE Workgroup, which we deferred to, said let's agree with that and just move on knowing that everybody's going to have to do a test when they do the real thing, which is coming in future stages when the environment's ready. We had suggested, based on the last call, that instead of the test, pass or fail, that there be one actual transmission. So that was option number four. Let's try to see whether we want to stick with option four or, as I said, we really wanted to defer to the IE Workgroup whether we can support their options and make it our recommendation as well, which is option one, which actually is the same thing as the NPRM suggested.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

Paul, this is Leslie. One of the discussions at the Standards Committee was that for certification purposes the EHR has to certify that it can go outside of itself and go into the NHIN or Direct or another vendor and demonstrate that, and that that be kept in if the eligible provider has the option to use those tools when communicating with external sources, but they may not have the need to communicate with external sources, as we discussed, in our rural setting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So one of the ways to allay our concerns as far as are we going to move the ball in functionality is what Leslie said, yes, it's already a requirement in the certification process, so we're going to have systems that can do this and we're mainly finding our way as far as what's the appropriate time when, again, across the country you can do this. The comments are option one or four essentially.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. This is Charlene. The provider's feedback on this, and again it's mixed but there's quite a bit of planning and infrastructure that they have to put in place to be able to even implement the test, and they have to think through the data capture. And I'll give you a concrete example, like for instance, okay, I've got to fulfill all the fields in one of these CDA forms, and therefore I've got to capture the data. And so even if it's 50%, what 50% of your patients aren't you going to fulfill the fields for. So it becomes a process which really drives data collection as well as prepares them for the future stages. So the feedback, again, was mixed, but there was strong feedback, and unless it's on the list of something we have to do with everything else we have to do we're not going to look at this until later, and so even the providers were encouraging that we keep something on the list to help them get ready because Stage 2's going to be more significant. Now, the counter argument on this one, and I have to comment on that too, is that the bar is going to be raised with Stage 2 to have a more sophisticated standard, so there's going to be a change when they move to Stage 2, so some of that work is going to have to be redone. So I could argue it both ways.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie again. And one of the discussions was also that the testing be more robust for the certification, so that you're not just testing that I can connect, but you're actually demonstrating a successful transaction in both directions, and so that that helps to advance things without having to – it doesn't keep things just status quo.

Eva Powell – National Partnership for Women & Families – Director IT

And the other thing to recall, kind of what Charlene just said, is that these criteria are in perpetuity, so as we move through time exchange is going to be more and more common, such that those who are getting on the escalator late are going to be in a very different environment than what we're in now, and so they

have nothing in Stage 1 Meaningful Use relevant to perhaps the thing that's of most value about the ... process, to me just seems really counterproductive.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I'm sorry, can you say that last part again?

Eva Powell – National Partnership for Women & Families – Director IT

Given that the environment in which later adopters enter Stage 1 that there will be more exchange happening than if we have them receive public money as an incentive for health IT and don't include something that shows that they are advancing their capability to provide the biggest benefit of that, I just think that's counterproductive. The benefit of health IT is not so much making data electronic, it's being able to exchange it. And if they're doing nothing to show that they're preparing for that, they should not get any money.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So that's speaking –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

..., so let's test that unintended consequence. Do we think it's unreasonable for everyone in the country to be conducting transmission with someone, so obviously I'm thinking of the rural communities now, is that unreasonable, does that not serve their primary patient care mission? Would they not have anybody to transmit data electronically with?

W

If you count commercial labs, everyone is doing that today, but that's not going to be a summary of care document, that's going to be labs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So in Stage 1 the "key" clinical information, that was probably the problems, meds list, that kind of thing, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, what we're saying, like even up in the pilot that's up in the Hudson Valley, the stuff with Direct, because the provision of this stuff is in place even now the practitioners when they get it say this is the Holy Grail and we can finally get information, because they're preparing for it. I think it would go faster if we keep it there. I can argue it both ways. It's back to Eva's ... platform.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. Is Yael still on? I'm thinking about the HRSA perspective.

Yael Harris - HRSA

I'm here, but I was on mute.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Do you have any ideas about the question I posed, so let's say in the rural communities do you think it's reasonable to require that someone has a vested interest in exchanging clinical data electronically with at least one clinical trading partner?

Yael Harris - HRSA

Absolutely, because you've got your rural health clinic and you've got your critical access hospital.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Yael Harris - HRSA

I think two may be difficult because there may just be one rural clinic.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. That's a good point. So all we're asking in option four is to say just start the process going and for the reasons that everyone's been saying it would be a shame to lose that by 2014. Do we have consensus around that, basically we're sticking with option four?

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

It sounds good to me. This is Leslie.

Greg Pace – Social Security Administration – Deputy CIO

This is Greg. I'm okay with it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, Charlene.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I'm sorry, I got called away for a second.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We're staying with option four.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Do we want to go with option four starting in 2014 or just option four, period?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Option four – oh, for Stage 1.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

In other words, there was some discussion at the Policy Committee meeting that another way to look at it is that we didn't – I can't remember why exactly but we said well, let's let the most output in 2014, in other words, when Stage 2 starts the people starting in Stage 1 should be doing option four.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

W

So it would be –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... backing off.

W

It would be optional for 2013 and then required in 2014.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

For Stage 1 or for Stage 2?

W

Stage 1.

M

For Stage 1.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Stage 1 starting in 2014 have to do this, because the ... advance. So I guess that the concern was, why did we do that? Because for 2012 and 2013 the feeling was –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Wait a minute, for option four what's the difference between Stage 1 and Stage 2 then?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Stage 2 has no test. You're supposed to be really exchanging information for real uses. So the question in Stage 1 is we said you get the person started by doing this thing which is like a real test and for some reason it came up that having the Stage 1ers do it in '12 and '13 was a problem, but they could start in 2014 maybe.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Could either Josh or Michelle clarify what's the question being asked, is it for Stage 2 or for a reconfigured Stage 1? And if it's a reconfigured Stage 1, what then is the difference between Stage 1 and Stage 2 by 2014?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

In 2014 Stage 2 has no test, we've already agreed to that. So the only question is for Stage 1, do they have a test? That's option four is that Stage 1 has a test; Stage 2 is off the table as having a test.

W

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So we're just deciding when Stage 2 has to continue to do this test. Our original recommendation is to have to continue to do it as of today. And this alternate proposal, which is in green on there, was well, maybe we pull it back and in 2014 when the other people are going to Stage 2 and doing real exchange of lots of information, med rec, all that stuff, that Stage 1ers have to do the test.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Boy, I'm pretty lost here.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... the value of that with the current rule is that they would have, in theory, Stage 2 software but it gets really convoluted.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Charlene, what is that? I see –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The value would be they don't have to – if they build it they'll build the consolidated CDA version as opposed to Stage 1 version and then Stage 2 version.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Maybe that was the reason we ended up there. I can't remember how we ended up with 2014. It had something to do with Stage 2 starting. Maybe it was the fact that they're using the same software.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

They don't have to do it twice, if you will.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, now it was presented that 2013's a bad year to do this test thing and 2014 was more reasonable. Maybe it was Charlene's reasons. Christine is the other person on the other side of the conversation but she's not on the phone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Maybe to help straighten myself out, can we talk about Stage 2 first and –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Stage 2 they said they're removing the test, and we agreed.

W

Paul, it might be helpful in the slides, slide 26 which talks about Stage1 but it actually might help with the conversation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, my printout's not labeled.

W

It's close to the back. It's labeled "Care Coordination."

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

W

So it shows the three care coordination measures for Stage 1, but it lists the change of things adjusted for Stage 1 with the four options, that might help.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It says "Stage 1 Proposed Changes," and then it says "Remove for Stage 2."

W

It's completely removed for Stage 2, but they're asking for comment on four different options for Stage 1.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And the only reason for calling it "Removed in Stage 2" is because Stage 1 obviously would precede in the Stage 2 time frame.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So if you're a new provider, new to Meaningful Use, in 2014 you're doing Stage 1 for two years before you get to Stage 2.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, and there's no need for testing, obviously, because you're already doing it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And we're not increasing the amount you have to do in Stage 2, is that what the implications are?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So is there any reason for not introducing this in Stage 2 alone?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

No one's considering the possibility of introducing a test in Stage 2.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Not a test, but actual transmission.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Even actual transmission of one thing is not being considered because you have to do 10% or 5% or whatever. I have to go back and look.

W

And, Paul, it's the use case tied to the transmission of the care summary, that's how we're –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, right, right.

W

Stage 2 is not a test, and actually the proposal for the change to Stage 1 is not a test either, it is an actual successful exchange of one real patient, or at least that's the option –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Right.

W

I think we should stop using the term “test” period, because –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

An exchange.

W

It's an exchange.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Now, then I guess one pushback is to say we're actually making Stage 1 more stringent. Is that allowed?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Currently there's a test in Stage 1, the NPRM in Stage 1, and the NPRM is saying you don't have to do that test anymore.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But it's adding the real exchange.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

And then what we're saying is, should we have the real exchange and then this alternate proposal in green on that original slide was well, maybe we give them until 2014 but in 2014 Stage 1ers have to do something. A minute ago we were voting yes in favor of option four, so the question is should we back off to 2014 and not do it this year, 2012 and 2013?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I assume this has been looked at in terms of can you increase – well, no, I guess you're right,

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... option.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think what we meant by option four is to do an actual transmission by 2014.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

That's my understanding, Leslie.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

What did you say, Paul? ... was we would strike the recommendation and keep the transmission in place, or option four in place, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But for 2014.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Oh, only 2014.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And beyond.

Eva Powell – National Partnership for Women & Families – Director IT

Can I ask a question ? This is Eva. I would be fine with that, but I guess what I'm concerned about is are we creating a gap of 2013 where we have eliminated the test but haven't yet instituted the real exchange. What difference is it for a vendor for that? This is my lack of technical knowledge, but if the vendor has to include the capability for the very first year of Stage 1 for exchange because of the test, why would it be problematic just to make sure that that test is successful and for a real patient, why would that involve any technical changes and therefore require the delay until 2014?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George. I think Stage 1's test is different than option four.

Eva Powell – National Partnership for Women & Families – Director IT

Oh yes, it is. It is but it's –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I wish I had – it may have been what Charlene said. Christine was in the conversation –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And I don't –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... and she said oh yes, maybe we should just ... and suggest instead of the compromise Stage 1 only as of 2014 – I see what you mean by ..., people have to test in 2011 and then do nothing in 2012 and 2013 and then they have to do this single transfer, which is a test like real transfer in 2014, so why not do it in '12 and '13. One answer would be simply that there's a reason why CMS is suggesting option one in the first place. That's the one they picked. And so they're backing off for some reason, I guess because they felt it wasn't that useful or it was too hard to do.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Well, they got lots of questions about it. The reasoning they gave was that it created more problems than it solved because they got so many questions about well, does it have to be successful and this isn't meaningful, and I'm just really concerned about having anyone getting federal money for meaningful use without doing anything with regard to exchange. So I'm in full agreement with eliminating the tests because like CMS said it's totally meaningless, it doesn't help anyone. However, there has to be something to get us on that path for exchange and the only thing that they have put in the rules that they're seeking comment on in terms of an alternative that actually gets that is the fourth option.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But the fourth option needs 18 months for the vendors to implement it. Remember most of our –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

That's what I don't understand is if the vendors are having to implement technology to do a test, why are they going to have to change that for that test to be successful and with a real patient?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, it's a different document. I think it's a different test. I think they're different requirements, right, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

No, actually—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Or is it the same?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The systems today are instrumented with the clinical summary and our customers populate that with data and actually do the tests, they don't actually do exchange. To do the exchange there's more work on their part, but they have to send it over, get validation that it got there, and they get validation, but they do that anyway. So on the vendor's part it's not additional work. What will change is for us to qualify for Stage 2 we have to rewrite the standard such that it meets the new requirements of the consolidated CDA, which means there's going to be more embedded content in it with problems and meds and that kind of stuff, so there's a lot of work that's got to happen to get to Stage 2, but with Stage 1 even though the vendors did it differently, if you will, it's still out there and it's working and we're getting some learnings coming from that process. And some people are actually doing exchange with it and sending data.

W

It sounds like this is not a vendor issue and so I don't know why we're even considering doing nothing in Stage 1 regardless of the year for exchange.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The difference would be if the customers go ahead and do that and then in Stage 2 we have to upgrade our software to be more sophisticated, then they're going to have to redo some of that work again. So for Stage 1 if they just do the test it's of very little value, and Stage 2 is when the value really comes. So you can argue it from that perspective. They do have to make some software changes to move to Stage 2.

W

Charlene, I guess I still don't understand –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

We've got to go on. So, Paul, our original recommendation was option four, that's what Eve was arguing for, and we can just stick to our original recommendation. The information Exchange Workgroup is telling us to back off and not do it, so that's interesting that the IE Workgroup is the one that's promoting this is telling us to back off, but that's for the Policy Committee to decide, not us. I'm neutral on this. Option four, we said yes and we're just now arguing well, we don't need to wait until 2014. And then the Policy Committee will have to decide to listen to the Information Exchange or Meaningful Use Workgroups.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

This is Leslie. I think the biggest issue is that the test process in Meaningful Use 1 was so vague and unable to be successful in it, so we're trying to fix that with actually showing transmission, and backing off will defeat the whole intent. So I'm with Eva on this one for sure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The other point was what were the transport mechanisms? There were gaps and all that stuff came to the fore, so that was confusing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's true that the test was actually counterproductive.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And even after doing a test we weren't better off, so if you have actual transmission in a live system you are actually better off once you do that, even if you only did it for one patient. But obviously people would find it, they'd take the right organization and they'd want to do it for ... than one patient. I think the only thing about timing is this rule does not become final until later this year, how realistic is it to change the Stage 1 requirement, and presumably that's why they were considering, let's say, 2014 certification.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

They asked us for one of four options, we picked four, and that's it. They have to figure out how to implement it.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so I think we've had a good discussion. We are having a difference of opinion surrounding the advancement of the ... for Stage 2, or ... for what we're doing by 2014. Good. Okay –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And as is, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We'll stay with option four.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay, all right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we can get this last one done on this page and that is, we had recommended for Med Rec it was menu at 50% in Stage 1, and we proposed just keeping it at 50% moving to core and the NPRM suggested going higher, and I think both we and the IE Workgroup were concerned that 65% might be too high.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So we all agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, they didn't say exactly what number. So I think we're staying with our recommendation for 50%.

W

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Good, maybe we can do one more.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, let me see, and we pointed out the interesting quandary is we actually have to have new functionality and a new field in the EHR to say a transition is about to occur because you otherwise can't get a denominator, and we used that more than once, but that's one of the implications of what we're saying.

The next piece has to do with summary of care, which I don't think we can do that in ten minutes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, but if the other ones are easier it might be better to start the hard one and not finish, rather than leave it for May 1st.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Here we're talking about in Stage 1 ... the summary of care was a menu option that was not widely adopted and that you must provide a summary of care record for at least half of the transitions or referrals. Now that ... does not mean electronic, it's just that the system has to be capable of and you be able to give to another provider a summary of care. Remember this is provider to provider. What we proposed was to make that core and that the instructions be presented and that we add some minimal requirements of care plan, or shared care plan, and those were goals and patient instructions, 10%, that's where we stood. The NPRM said raise it from 50% to 65%, so I was raising it, and that there was an additional part two that you had to have transmitted the summary of care document electronically for at least 10% of your transition and that it be ... into a different EHR. So we came back and said that we agree with transmitting – let's see, did we agree to 10%? I don't see different in our –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

No, we left it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's 10% --

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... messages, we just commented on there questions about different organization and –

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. We agreed with the different organizations. We did not agree with the different EHR as a requirement because in some geographic regions it doesn't actually make sense –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

On the percent, we did disagree with the percent, but we couldn't come up with an answer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That's the last sentence. Remember, we were deciding on 10%, 5%, or 25 counts.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Okay, so we have a number of elements to discuss. Let me go with the easiest one, I think, that we still believe that it should not require a different EHR, that basically you've got some geographic regions that are highly automated, have the incentives, and now we have to come up with some ... just to fulfill this requirement. Do we still agree with that?

W

Yes.

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, I think we heard that from everybody, so that's why I thought that was easy. Okay, now let's talk about the 10% required electronic exchange. So remember, one, we have to have a new manual step, there's the new EHR functionalities, the new data fields, and it's a new manual step because only the provider can know what is about to happen, i.e. the transition that is about to happen. So that was one of the things that influenced our prior comment in terms of, let's say, Med Rec. So that may come into play here too. Are we ready to set a threshold for electronically exchanged data, at the summary of care record? And the other piece of course is and do you have a receiving partner?

Eva Powell – National Partnership for Women & Families – Director IT

Paul, this is Eva. I don't know the answer on this, but I think for me what I'm really, really concerned about on this one is that that is where CMS has put all of the eggs in the basket for exchange for Stage 2, because as you recall from our previous conversation, the test has been eliminated and they've gone in Stage 2 to a use case scenario for exchange, which is good because it makes it more meaningful. But this is the use case and, like I said, I don't know the answer here because this criterion serves two purposes; it's an informational purpose for transfers and referrals, and it's also an exchange purpose, that because it is the only exchange purpose and the only thing that drives exchange really in Stage 2, I have a really hard time accepting, first of all, a low threshold of 10%, and second of all, providing any option whatsoever for a paper version. But then what I have a problem with there is that if we don't have an option for paper then we may defeat the purpose of the exchange of the information transfer. So I bring that up because I think it's part of the complication of this and I know that the 10% people view that

maybe as being high, but I think the critical piece to keep in mind as we talk about this is that this is exchange in Stage 2 and Stage 2 is supposed to be all about exchange, and if we're requiring a measly 10% for transfers and referrals, I think we've really dropped the ball. Like I said, I don't know the answer, but that to me is probably one of the most important parts of this discussion.

Leslie Kelly Hall – Senior Vice President for Policy – Healthwise

I would echo that. This is Leslie. And also ... that there's been huge work already being done on transitions of care technically in the transitions of care S&I framework, so people are operating and moving toward this eventuality and I think feel strongly that we've got to keep it in.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George. I guess in theory this is good. In practice actually implementing this at a certain threshold is hard and I think I voted for 5%, kind of where Paul was headed, that this is actually pretty hard to do, similar to the patient initiated secure messaging, and that's where I got my 5% number from. I understand the problem that Eva's bringing up, that if this is not information exchange then we lowered this one too low, and that's why I'm not saying that 25 counts, but again I'm coming in at the 5% level and realizing that ... the problem, I just think this is hard to do.

Eva Powell – National Partnership for Women & Families – Director IT

George, tell me why it's hard to do, and that's a naïve question, I know it sounds like it, and I think also the important thing to think is that we're talking Stage 2, which is 2014, we're two years away, and what exactly is hard about this?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Finding your partners in your neighborhood that are capable of receiving it, because it involves interaction like if you're in a neighborhood that has a RHIO then maybe this isn't so hard, but if you're in the middle of nowhere and trying to do this –

Eva Powell – National Partnership for Women & Families – Director IT

But remember I can send this in Direct and so that's being capable, or being compatible with the ... that offers the direct messaging capability and can send this document.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, but it's something that I don't have control. Let me put it this way, it's in the class of objectives that I don't control, like patient initiated messages, patient reviewing the record, and in this case having a partner to send it to and say that they got it and ... work with me, are why this one's a little harder. ... something I completely control.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. I see what you're saying and I would agree that this is hard, but I also want to remind folks that we're in the concept of care coordination and that is not something that anyone does by themselves and therefore inherent in this is lack of total control. So I don't think that's a valid reason to not push the envelope on this. And it sounds like to me that what makes this hard is that there are infrastructure issues and there are relationship issues, and in my mind that's part of what we need to be driving with this and so to have a really miniscule threshold of 5%, I don't see that that is good stewardship of this type of ... money for us. What I would advocate for this, but I still think there's the issue of the information transfer, is make paper unacceptable unless there's truly no broadband access anywhere, which is already in the rule as an exception for everything, and then have probably lower than 65, but have a robust percent of care summaries provided for transitions and referrals electronically. I'm thinking 35, but that's totally random. And that then will force relationship building if it's not already.

But people have referral patterns, they have relationships, so then what's necessary is to talk with them, which again is part of care coordination, and say, hey we've got to do this because I want my bonus, don't you want yours. And there's Direct, so that's free, and let's exchange doing this. And so I see what you're saying about it being hard because this is outside of the way that care's provided today, but the reasons why it's hard are exactly what we want to get at, we want to get at providers having relationships with one another such as they communicate about patients' care. So I just can't, in good conscience, go along with just a mamby-pamby percent like 5%. I think it has to be at least 30%, and I don't see paper being acceptable at all, ever, unless there's this rural part of Montana that has no broadband access for 100 miles.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So let me just give you something to think about, we have to close off and we'll continue this next call, one is the principle that I think almost any percent is a big deal in the sense of good. Once you have communication going, you're going to take advantage of ... because people love the electronic exchange of information. Any threshold will cause that to happen. The reason for, and I agree with George, the reason for having a low threshold is because you're worried about across America, so in particular rural parts of the country, for example, let's say you have a very good need to communicate from the practice to the hospital, but not 30% of your patients are getting admitted all the time hopefully. So that's a reason why any percent is going to make the transfer happen, but you don't want to inadvertently penalize folks that don't have the volumes that are needed to meet a threshold just to get the So that's something for you to think about in terms of preparing for the next call. We do need to open it up to public comment and then we'll continue this discussion here where we left off on May 1st.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Okay, operator, can you open up the lines for public comment, please?

Operator

(Instructions given.) We do not have any comments at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you. Well, thanks for a very vigorous discussion.

W

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We got through a lot of material and I think we came up with a good consensus, and some of it doesn't necessarily agree with some of our partner workgroups, but we have a good rationale. So we will continue the discussion next time, and hopefully get through everything in preparation for our May 2nd delivery to the Policy Committee. Thanks, everyone.

W

Thank you.

W

Thanks, Paul.

W

Thank you.

M

Thank you.

W

Have a nice weekend.